



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-3364-PN]

Medicare and Medicaid Programs: **Application from the Joint Commission (TJC) for Continued Approval of its Psychiatric Hospital Accreditation Program**

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice with request for comment.

SUMMARY: This proposed notice acknowledges the receipt of an application from the Joint Commission (TJC) for continued recognition as a national accrediting organization for psychiatric hospitals that wish to participate in the Medicare or Medicaid programs.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on **[OFR insert date 30 days after date of publication in the Federal Register]**.

ADDRESSES: In commenting, refer to file code CMS-3364-PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the "Submit a comment" instructions.
2. By regular mail. You may mail written comments to the following address **ONLY**:

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-3364-PN,
P.O. Box 8010,
Baltimore, MD 21244-8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-3364-PN,
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

For information on viewing public comments, see the beginning of the "SUPPLEMENTAL INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Karena Meushaw (410) 786-6609, Monda Shaver (410) 786-3410 or
Marie Vasbinder (410) 786-8665.

SUPPLEMENTAL INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period

are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services from a psychiatric hospital provided certain requirements are met. Section 1861(f) of the Social Security Act (the Act) establishes distinct criteria for facilities seeking designation as a psychiatric hospital. Regulations concerning provider agreements are at 42 CFR part 489 and those pertaining to activities relating to the survey and certification of facilities are at 42 CFR part 488. The regulations at 42 CFR part 482 subparts A, B, C and E specify the minimum conditions that a psychiatric hospital must meet to participate in the Medicare program, the scope of covered services and the conditions for Medicare payment for psychiatric hospitals.

Generally, to enter into a provider agreement with Medicare, a psychiatric hospital must first be certified by a State survey agency as complying with the conditions or requirements set forth in part 482 subpart A, B, C and E of our CMS regulations. Thereafter, the psychiatric hospital is subject to regular surveys by a State survey agency to determine whether it continues to meet these requirements. There is an alternative, however, to surveys by State agencies.

Section 1865(a)(1) of the Act provides that, if a provider entity demonstrates through accreditation by a CMS-approved national accrediting organization (AO) that all applicable Medicare conditions are met or exceeded, we may deem the provider entity as having met the

requirements. Accreditation by an AO is voluntary and is not required for Medicare participation.

If an AO is recognized by CMS as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body's approved program may be deemed to meet the Medicare conditions. An AO applying for approval of its accreditation program under part 488, subpart A, must provide CMS with reasonable assurance that the AO requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning the approval of AO are set forth at § 488.5. Our regulations at § 488.5(e)(2)(i) require an accrediting organization to reapply for continued approval of its accreditation program(s) every 6 years or sooner, as determined by CMS.

The Joint Commission's current term of approval for their psychiatric hospital accreditation program expires February 25, 2019.

II. Provisions of the Proposed Notice

A. Approval of Deeming Organizations

Section 1865(a)(2) of the Act and our regulations at § 488.5 require that our findings concerning review and approval of an AO's requirements consider, among other factors, the applying AO's requirements for accreditation; survey procedures; resources for conducting required surveys; capacity to furnish information for use in enforcement activities; monitoring procedures for provider entities found not in compliance with the conditions or requirements; and ability to provide CMS with the necessary data for validation.

Section 1865(a)(3)(A) of the Act further requires that we publish, within 60 days of

receipt of an organization's complete application, a notice identifying the national accrediting body making the request, describing the nature of the request, and providing at least a 30-day public comment period. We have 210 days from the receipt of a complete application to publish notice of approval or denial of the application.

The purpose of this proposed notice is to inform the public of TJC's request for CMS-approval of its psychiatric hospital accreditation program. This notice also solicits public comment on whether TJC's requirements meet or exceed the Medicare conditions of participation (CoPs) for psychiatric hospitals.

B. Evaluation of Deeming Authority Request

TJC submitted all the necessary materials to enable us to make a determination concerning its request for CMS-approval of its psychiatric hospital accreditation program. This application was determined to be complete on July 30, 2018. Under section 1865(a)(2) of the Act and our regulations at § 488.5 (Application and re-application procedures for national accrediting organizations), our review and evaluation of TJC will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of TJC's standards for psychiatric hospitals as compared with CMS' psychiatric hospital CoPs.
- TJC's survey process to determine the following:
 - ++ The composition of the survey team, surveyor qualifications, and the ability of the organization to provide continuing surveyor training.

++ The comparability of TJC's processes to those of State agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

++ TJC's processes and procedures for monitoring a psychiatric hospital found out of compliance with the TJC's program requirements. These monitoring procedures are used only when TJC identifies noncompliance. If noncompliance is identified through validation reviews or complaint surveys, the state survey agency monitors corrections as specified at § 488.9(c).

++ TJC's capacity to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.

++ TJC's capacity to provide CMS with electronic data and reports necessary for effective validation and assessment of the organization's survey process.

++ The adequacy of TJC's staff and other resources, and its financial viability.

++ TJC's capacity to adequately fund required surveys.

++ TJC's policies with respect to whether surveys are announced or unannounced, to assure that surveys are unannounced.

++ TJC's agreement to provide CMS with a copy of the most current accreditation survey together with any other information related to the survey as CMS may require (including corrective action plans).

III. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review

by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35).

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "**DATES**" section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

Upon completion of our evaluation, including evaluation of comments received as a result of this notice, we will publish a final notice in the **Federal Register** announcing the result of our evaluation

V. Regulatory Impact Statement This proposed notice does not impose any regulatory impact.

In accordance with the provisions of Executive Order 12866, this regulation was not reviewed by the Office of Management and Budget.

Dated: August 6, 2018.

Seema Verma,

Administrator,

Centers for Medicare & Medicaid Services.

[Billing Code: 4120-01-P]

[FR Doc. 2018-17519 Filed: 8/14/2018 8:45 am; Publication Date: 8/15/2018]